

South Carolina Department of Health and Human Services  
Healthy Connections Plans for Children Under Age 19 Worksheet

<b>Primary Individual</b>				<b>Date:</b>
	<i>First</i>	<i>Middle</i>	<i>Last</i>	<b>Household Number:</b>
<b>Case Action:</b> <input type="checkbox"/> Application <input type="checkbox"/> Review <input type="checkbox"/> Re-budget				<b>BG Number:</b>

Budget Group (BG) Adult Members	Date of Birth	Relationship to Primary Individual	Marital Status	Social Security Number
1.		Self		
2.				

Type of Income	Income of AG Members			
Earned Income			Children	Totals
1 Gross Earned Income				
2 Earned Income Disregard				
3 Total Disregards				
4 Subtotal				
Unearned Income				
5 Child Support Payments				
6 SSA Benefits				
7 VA Benefits				
8 Pension				
9 UCI Benefits				
10 Contributions				
11 Other				
12 Gross Unearned Income				
13 Child Care Deduction				
14 Incapacitated Adult Care Paid				
<b>Resource Eligible:</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Net Income:</b>

Budget Group Size:		Income Limit:			Federal Poverty Level: %		
Children in HH	Social Security Number	Non-Financial Criteria Met	Date of Birth	Age	Dependent of SC State Employee w/ access to SHP	Current or Dropped Health Insurance	Result
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10.		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Retroactive Eligibility requested for Medicaid and/or Medicaid Expansion?   ☐ Yes   ☐ No

Is Retroactive Eligibility Approved?   ☐ Yes   ☐ No      Month of Eligibility \_\_\_\_\_

<b>Eligibility Worker's Signature</b>	<b>Act on Decision Date (HCK)</b>	<b>MGC Cut-Off Date (HCK)</b>	<b>Month of Eligibility (HCK)</b>